Act (PRA) of 1995, the Federal Communications Commission (FCC or the Commission) invites the general public and other Federal agencies to take this opportunity to comment on the following information collection. Comments are requested concerning: Whether the proposed collection of information is necessary for the proper performance of the functions of the Commission, including whether the information shall have practical utility; the accuracy of the Commission's burden estimate; ways to enhance the quality, utility, and clarity of the information collected; ways to minimize the burden of the collection of information on the respondents, including the use of automated collection techniques or other forms of information technology; and ways to further reduce the information collection burden on small business concerns with fewer than 25 employees.

The FCC may not conduct or sponsor a collection of information unless it displays a currently valid control number. No person shall be subject to any penalty for failing to comply with a collection of information subject to the PRA that does not display a valid Office of Management and Budget (OMB) control number.

DATES: Written PRA comments should be submitted on or before December 13, 2021 If you anticipate that you will be submitting comments, but find it difficult to do so within the period of time allowed by this notice, you should advise the contact listed below as soon as possible.

ADDRESSES: Direct all PRA comments to Nicole Ongele, FCC, via email *PRA@fcc.gov* and to *nicole.ongele@fcc.gov*.

FOR FURTHER INFORMATION CONTACT: For additional information about the information collection, contact Nicole Ongele, (202) 418–2991.

SUPPLEMENTARY INFORMATION:

OMB Control Number: 3060–0719.

Title: Quarterly Report of Local Exchange Carriers Listing Payphone Automatic Number Identifications (ANIs).

Form Number: N/A.

Type of Review: Extension of a currently approved collection.

Respondents: Business or other for-profit entities.

Number of Respondents: 400 respondents; 1,600 responses.

Estimated Time per Response: 3.5 hours (8 hours for the initial submission; 2 hours per subsequent submission—for an average of 3.5 hours per response).

Frequency of Response: Quarterly reporting requirement, recordkeeping requirement and third party disclosure requirement.

Obligation to Respond: Required to obtain or retain benefits. Statutory authority for this information collection is contained in 47 U.S.C. 151, 154, 201–205, 215, 218, 219, 220, 226 and 276 of the Communications Act of 1934, as amended.

Total Annual Burden: 5,600 hours.

Total Annual Cost: No cost.

Privacy Act Impact Assessment: No impact(s).

Nature and Extent of Confidentiality: The Commission is not requesting respondents to submit confidential information to the Commission. If the respondents wish confidential treatment of their information, they may request confidential treatment under 47 CFR 0.459 of the Commission's Rules.

Needs and Uses: The Commission adopted rules and policies governing the payphone industry under section 276(b)(1)(A) of the Telecommunications Act of 1996 (the Act) and established ''a per call compensation plan to ensure that all payphone service providers are fairly compensated for each and every completed intrastate and interstate call.'' Pursuant to this mandate, and as required by section 64.1310(d) of the Commission's rules, Local Exchange Carriers (LECs) must provide to carriers required to pay compensation pursuant to section 64.1300(a), a quarterly report listing payphone ANIs. Without provision of this report, resolution of disputed ANIs would be rendered very difficult. Carriers would not be able to discern which ANIs pertain to payphones and therefore would not be able to ascertain which dial-around calls were originated by payphones for compensation purposes. There would be no way to guard against possible fraud. Without this collection, lengthy investigations would be necessary to verify claims. The report allows carriers to determine which dial-around calls are made from payphones. The information must be provided to third parties. The requirement would be used to ensure that LECs and the carriers required to pay compensation pursuant to 47 CFR 64.1300(a) of the Commission's rules comply with their obligations under the Telecommunications Act of 1996.

Federal Communications Commission.

Marlene Dortch,

Secretary, Office of the Secretary.

[FR Doc. 2021–22111 Filed 10–8–21; 8:45 am]

BILLING CODE 6712–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Agency for Healthcare Research and Quality

Supplemental Evidence and Data Request on Telehealth for Women

AGENCY: Agency for Healthcare Research and Quality (AHRQ), HHS.

ACTION: Request for supplemental evidence and data submissions.

SUMMARY: The Agency for Healthcare Research and Quality (AHRQ) is seeking scientific information submissions from the public. Scientific information is being solicited to inform our review on *Telehealth for Women,* which is currently being conducted by the AHRQ's Evidence-based Practice Centers (EPC) Program. Access to published and unpublished pertinent scientific information will improve the quality of this review.

DATES: *Submission Deadline* on or before November 12, 2021.

ADDRESSES:

Email submissions: epc@ahrq.hhs.gov.

Print submissions:

Mailing Address: Center for Evidence and Practice Improvement, Agency for Healthcare Research and Quality, ATTN: EPC SEADs Coordinator, 5600 Fishers Lane, Mail Stop 06E53A, Rockville, MD 20857.

Shipping Address (FedEx, UPS, etc.): Center for Evidence and Practice Improvement, Agency for Healthcare Research and Quality, ATTN: EPC SEADs Coordinator, 5600 Fishers Lane, Mail Stop 06E77D, Rockville, MD 20857.

FOR FURTHER INFORMATION CONTACT: Jenae Benns, Telephone: 301–427–1496 or Email: *epc@ahrq.hhs.gov.*

SUPPLEMENTARY INFORMATION: The Agency for Healthcare Research and Quality has commissioned the Evidence-based Practice Centers (EPC) Program to complete a review of the evidence for *Telehealth for Women.* AHRQ is conducting this technical brief pursuant to Section 902 of the Public Health Service Act, 42 U.S.C. 299a.

The EPC Program is dedicated to identifying as many studies as possible that are relevant to the questions for each of its reviews. In order to do so, we are supplementing the usual manual and electronic database searches of the literature by requesting information from the public (*e.g.,* details of studies conducted). We are looking for studies that report on *Telehealth for Women,* including those that describe adverse

events. The entire research protocol is available online at: *https://effectivehealthcare.ahrq.gov/products/telehealth-women/protocol*.

This is to notify the public that the EPC Program would find the following information on *Telehealth for Women* helpful:

- A list of completed studies that your organization has sponsored for this indication. In the list, please *indicate whether results are available on ClinicalTrials.gov along with the ClinicalTrials.gov trial number.*
- *For completed studies that do not have results on ClinicalTrials.gov,* a summary, including the following elements: Study number, study period, design, methodology, indication and diagnosis, proper use instructions, inclusion and exclusion criteria, primary and secondary outcomes, baseline characteristics, number of patients screened/eligible/enrolled/lost to follow-up/withdrawn/analyzed, effectiveness/efficacy, and safety results.
- *A list of ongoing studies that your organization has sponsored for this indication.* In the list, please provide the *ClinicalTrials.gov* trial number or, if the trial is not registered, the protocol for the study including a study number, the study period, design, methodology, indication and diagnosis, proper use instructions, inclusion and exclusion criteria, and primary and secondary outcomes.
- Description of whether the above studies constitute *ALL Phase II and above clinical trials* sponsored by your organization for this indication and an index outlining the relevant information in each submitted file.

Your contribution is very beneficial to the Program. Materials submitted must be publicly available or able to be made public. Materials that are considered confidential; marketing materials; study types not included in the review; or information on indications not included in the review cannot be used by the EPC Program. This is a voluntary request for information, and all costs for complying with this request must be borne by the submitter.

The draft of this review will be posted on AHRQ's EPC Program website and available for public comment for a period of 4 weeks. If you would like to be notified when the draft is posted, please sign up for the email list at: *https://www.effectivehealthcare.ahrq.gov/email-updates.*

The systematic review will answer the following questions. This information is provided as background. AHRQ is not requesting that the public provide answers to these questions.

Key Questions (KQs)

KQ 1: For conditions related to women's reproductive health (including family planning, contraception, and sexually transmitted infection counseling):

(a) What is the evidence of effectiveness of telehealth as a strategy for delivery of health care services for reproductive health?

(b) What are patient preferences and patient choice in the context of telehealth utilization?

(c) What is the effectiveness of patient engagement strategies for telehealth?

(d) What is the impact of COVID–19 on the effectiveness of telehealth and patient engagement?

(e) What are the barriers to and facilitators of telehealth for women's reproductive health in low-resources settings and populations?

(f) What are the harms of telehealth for women's reproductive health?

KQ 2: For interpersonal violence (including intimate partner violence and domestic violence):

(a) What is the evidence of effectiveness of telehealth as a strategy for screening and interventions for interpersonal violence?

(b) What are patient preferences and patient choice in the context of telehealth utilization?

(c) What is the effectiveness of patient engagement strategies for telehealth?

(d) What is the impact of COVID–19 on the effectiveness of telehealth and patient engagement?

(e) What are the barriers to and facilitators of telehealth for screening and interventions for interpersonal violence in low-resources settings and populations?

(f) What are the harms of telehealth for screening and interventions for interpersonal violence?

Contextual Question: What guidelines, recommendations or best practices have been developed for the design and use of telehealth and virtual health technologies for women for any clinical conditions, including on patient preferences, patient choice, patient engagement, and implementation in low-resource settings?

PICOTS (Population, Intervention, Comparator, Outcome, Timing, Setting)

Tables 1 and 2 shows full eligibility criteria to identify studies that address the KQs.

TABLE 1—PICOTS AND CORRESPONDING INCLUSION AND EXCLUSION CRITERIA

	Include	Exclude
Population	Adolescent and adult women (age 13 years and older), including those who are pregnant, eligible for screening, counseling, or treatment for: KQ 1: Reproductive health services: (Family planning, contraception, STI counseling). KQ 2: Interpersonal violence.	• Men. • Children under 13.
Interventions	KQ1: Reproductive health services: • Family planning (preconception counseling and care). • Contraception (screening, counseling, provision, and follow-up care). • STI counseling. KQ2: Interpersonal violence (intimate partner violence, domestic violence). KQ 1a, 1b, 1e, 1f, 2a, 2b, 2e, and 2f: Telehealth and virtual health, defined as: • Any two-way telehealth strategy intended to supplement or replace traditional in-person care (*e.g.,* virtual visits, remote monitoring, mobile applications, at-home use of medical devices, use of a facilitator; use of patient-portal or electronic medical record). • Must include direct contact between a clinician or other provider and a patient or group of patients. • Telehealth can be synchronous or asynchronous. • Interventions may be comprised of a single telehealth strategy or may be delivered as telehealth packages, comprised of multiple telehealth strategies.	• KQ1: Non-FDA-approved contraceptive devices, medications, and other methods that are not currently in clinical use in the U.S. as of 2021. • Telehealth clinician-to-clinician consults. • Interventions without bidirectional communication between the patient and the health care team (*e.g.,* one way email or text messages). • Peer-led interventions

TABLE 1—PICOTS AND CORRESPONDING INCLUSION AND EXCLUSION CRITERIA—Continued

	Include	Exclude
	KQ 1c, 1d, 2c, and 2d: Patient engagement strategies using telehealth and virtual health.	(no clinician involvement). • Maternity Care.
Comparators	• For effectiveness and harms (KQ 1a, 1c, 1d, 1f, 2a, 2c, 2d, 2f): Usual or in-person care or traditional care models (care provided without telehealth); telehealth + in-person care vs. in-person care alone (augmentation). • For barriers, facilitators, preferences (KQ 1b, 1e, 2b, 2e): Studies with or without comparison groups (*i.e.,* patients' perceptions are based on comparisons of their own previous experiences). • KQ 1d and 2d: During COVID–19: Clinical services before and after COVID–19 pandemic.	No comparison for effectiveness and harms.
Outcomes	See Table 2.	• Outcomes not relevant to the KQs. • Cost analyses. • Patient knowledge/education.
Clinical Setting	• Home, outpatient, primary care, or primary care-referable. • Contact can be simultaneous (synchronous) or communicating across time (asynchronous). • Individuals providing care include a broad range of health care workers (physicians, nurses, pharmacists, counselors, etc.). • No geographic restriction: Can be urban, suburban, or rural.	Studies of health care services delivered outside of health care settings (*e.g.,* social services, churches, schools, prisons).
Country Setting	Research conducted in the U.S. or in populations similar to U.S. populations, with services and interventions applicable to U.S. practice (*i.e.,* countries with a United Nations HDI of ''very high'').	Countries with significantly different health care systems and fewer resources (*e.g.,* low-income countries); not rated 'very high' on the 2018 HDI.
Study types and designs	• RCTs. • A best evidence approach will be used for considering inclusion of observational studies (non-RCT with some type of comparison): ○ Comparative studies including trial and observational studies, including prospective and retrospective cohort studies and before-after studies (*i.e.,* natural experiments). ○ Qualitative studies that evaluate preferences, barriers/facilitators. ○ Studies that specifically note that they were conducted during the COVID–19 pandemic (*e.g.,* either specify they are assessing effects of COVID–19, or compare practices before and after March 2020) will be included. Studies with data that overlap this period will be considered only if results are stratified by pre-post pandemic.	Case reports, case series.
Language	English language.	Non-English.

Abbreviations: COVID–19 = novel coronavirus; FDA = U.S. Food and Drug Administration; HDI = human development index rating; KQ = key question; RCT = randomized controlled trial; STI = sexually transmitted infection; U.S. = United States.

TABLE 2—TABLE OF OUTCOMES

Category	Included outcomes
All conditions/services	KQ 1a and 2a: • Clinical effectiveness, patient health outcomes (see specific outcomes). • Quality of life, function. KQ 1b, 1c, 1d, 2b, 2c, and 2d: Measures or descriptions of patient satisfaction, patient engagement and activation, patient choice. KQ 1e and 2e: Measures or descriptions of barriers and facilitators in low-resource settings. • Patient-reported outcomes: Patient empowerment, engagement, and satisfaction. • Measures of health care access, equity, and utilization. ○ Rates of screening and followup; adherence; no-shows. ○ Utilization of services. • KQ 1f and 2f: Harms (*e.g.,* missed diagnosis, incorrect diagnosis, overdiagnosis, delay in treatment, increase in redundant testing or in low-value care, mental health outcomes, stress, anxiety, loss to followup).
Family planning	• Desired pregnancy; unwanted/unintended pregnancy. • Interpregnancy interval. • Resource utilization.
Contraception	• Reduced unintended or unwanted pregnancy and births. • Increased contraceptive use/uptake. • Change in contraceptive method. • Reproductive health outcomes. • Harms associated with contraceptive care (*e.g.,* complications of contraceptive methods; delayed method start; unable to start method of choice; reproductive coercion).
STI counseling	• Health outcomes:

TABLE 2—TABLE OF OUTCOMES—Continued

Category	Included outcomes
IPV	○ STI incidence (based on testing/biologic confirmation). ○ STI complications. • Behavioral outcomes: ○ Changes in STI risk behaviors (*e.g.,* multiple sexual partners, concurrent sexual partners, sexual partners with high STI risk, unprotected sexual intercourse or contact, sex while intoxicated with alcohol or other substances, sex in exchange for money or drugs). ○ Changes in protective behaviors (*e.g.,* sexual abstinence; mutual monogamy; delayed initiation of intercourse or age of sexual debut; use of condoms, other barrier methods, or chemical barriers; or other changes in sexual behavior). • STI harms: ○ Health care avoidance. ○ Psychological harms (*e.g.,* anxiety, shame, guilt, stigma). • Health outcomes: ○ Reduced exposure to IPV as measured by a validated instrument (*e.g.,* Community Composite Scale), self-report frequency of abuse (*e.g.,* number of physical/sexual assaults), or discontinuation of an unsafe relationship. ○ Physical morbidity caused by IPV, including acute physical trauma (*e.g.,* fractures, dislocations). ○ Mental health morbidity caused by IPV, including acute mental morbidity (*e.g.,* stress, nightmares) and chronic mental health conditions (*e.g.,* posttraumatic stress disorder, anxiety, depression). ○ Sexual trauma, unintended pregnancy, pregnancy loss, and sexually transmitted infections. ○ Health care utilization attributed to physical or mental effects of IPV (*e.g.,* rates of emergency room visits). ○ Social isolation. • Harms: ○ Increased abuse or other forms of retaliation; and other reported harms of screening or identification.

Abbreviations: IPV = interpersonal violence; KQ = key question; STI = sexually transmitted infections.

Marquita Cullom,

Associate Director.

[FR Doc. 2021–22074 Filed 10–8–21; 8:45 am]

BILLING CODE 4160–90–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Final Effect of Designation of a Class of Employees for Addition to the Special Exposure Cohort

AGENCY: National Institute for Occupational Safety and Health (NIOSH), Centers for Disease Control and Prevention, Department of Health and Human Services (HHS).

ACTION: Notice.

SUMMARY: HHS gives notice concerning the final effect of the HHS decision to designate a class of employees from the Savannah River Site in Aiken, South Carolina, as an addition to the Special Exposure Cohort (SEC) under the Energy Employees Occupational Illness Compensation Program Act of 2000.

FOR FURTHER INFORMATION CONTACT: Grady Calhoun, Director, Division of Compensation Analysis and Support, NIOSH, 1090 Tusculum Avenue, MS C–46, Cincinnati, OH 45226–1938, Telephone 513–533–6800. Information requests can also be submitted by email to *DCAS@CDC.GOV.*

SUPPLEMENTARY INFORMATION: On August 18, 2021, as provided for under 42 U.S.C. 7384*l*(14)(C), the Secretary of HHS designated the following class of employees as an addition to the SEC:

All construction trade employees of Department of Energy subcontractors [excluding employees of the following prime contractors who worked at the Savannah River Site in Aiken, South Carolina, during the specified time periods: E. I. du Pont de Nemours and Company, October 1, 1972, through March 31, 1989; and Westinghouse Savannah River Company, April 1, 1989, through December 31, 1990], who worked at the Savannah River Site from October 1, 1972, through December 31, 1990, for a number of work days aggregating at least 250 work days, occurring either solely under this employment or in combination with work days within the parameters established for one or more other classes of employees included in the Special Exposure Cohort.

This designation became effective on September 17, 2021. Therefore, beginning on September 17, 2021, members of this class of employees, defined as reported in this notice, became members of the SEC.

Authority: 42 U.S.C. 7384q(b). 42 U.S.C. 7384*l*(14)(C).

John J. Howard,

Director, National Institute for Occupational Safety and Health.

[FR Doc. 2021–22132 Filed 10–8–21; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. FDA–2021–N–0966]

Closer to Zero Action Plan: Impacts of Toxic Element Exposure and Nutrition at Different Crucial Developmental Stages; Public Meeting; Request for Comments

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice of public meeting; request for comments.

SUMMARY: The Food and Drug Administration (FDA or we) is announcing the following virtual public meeting entitled ''Closer to Zero Action Plan: Impacts of Toxic Element Exposure and Nutrition at Different Crucial Developmental Stages.'' The purpose of the public meeting is to discuss the scope of the Closer to Zero action plan as it relates to the impacts of toxic element exposure and nutrition at different crucial developmental stages, including discussion of the key nutrients in food for growth and development, foods commonly consumed by babies and young children, and exposure risks of toxic elements.

DATES: The public meeting will be held on November 18, 2021, from 10 a.m. to 4 p.m. Eastern Time. FDA is